UNITED STATES DEPARTMENT OF STATE

Bureau of Educational and Cultural Affairs

Accident and Sickness Program for Exchanges

INSTRUCTIONS FOR COMPLETING INSURANCE CLAIM FORM

In order for your claim payment to be processed promptly, please complete this check list prior to submitting a claim for reimbursement.

☐ Did you include a **copy of your ASPE Identification Card**?

PART A - TO BE COMPLETED BY MEMBER

☐ Is your full name (first, middle, and last) included in the **NAME OF INSURED** box?

☐ Did you include a **mailing address** in the United States?

CLAIM INFORMATION

☐ Did you include all information related to your **sickness** including **details** related to having the **same or a similar condition**?

☐ Did you state the **diagnosis**? A diagnosis must also be included for pharmacy expenses related to the sickness.

MEDICAL DATA AUTHORIZATION

☐ Have you signed and dated the **Medical Data Authorization**?

ASSIGNMENT OF INSURANCE BENEFITS - AUTHORIZATION TO PAY

☐ If you would like the United States Department of State to make **payment to the physician or hospital**, did you sign and date the **Assignment of Insurance Benefits**?

PAYMENT TO BE MADE TO MEMBER

☐ If you would like the United States Department of State to make **payment to you** (the member), did you include **itemized receipts**? Your United States mailing address will be used for reimbursement unless you identify a different reimbursement address on the claim form.

PART B - ATTENDING PHYSICIAN'S STATEMENT

(This section should only be filled out by the provider, but you should check it for completeness before submitting your claim for reimbursement)

☐ Did the provider list the **diagnosis**?

☐ Did the provider list the **description of services** and **CPT codes**?

☐ Did the provider include their **Federal Tax ID number** on the claim?

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Accident and Sickness Program for Exchanges

MAIL THIS FORM TO:
United States Department of State
ATTN: CLAIMS
P.O. BOX 33729
INDIANAPOLIS IN 46203-0729
1-800-299-8742

ADMINISTERED BY:
Outsourced Administrative Systems, Inc.

INSTRUCTIONS FOR FILING CLAIM:

1. Insured **must** complete this side of form.
2. Have your provider complete the back of this form.
3. Diagnosis must appear on either this form or bill.
4. Please do not mail this form, bills or receipts until completion of medical treatment unless treatment will continue beyond 20 days following the inception date of the accident or sickness.
5. A copy of your ASPE ID must accompany form.

TO BE COMPLETED BY INSURED

INCOMPLETE CLAIM FORMS WILL RESULT IN PAYMENT DELAY

CLAIMANT INFORMATION

NAME OF INSURED (First Name, Middle Name, Last Name)	DATE OF BIRTH	HOME COUNTRY

U.S. MAILING ADDRESS	U.S. TELEPHONE NUMBER

FOREIGN MAILING ADDRESS	FOREIGN TELEPHONE NUMBER

NAME OF SCHOOL OR UNIVERSITY AFFILIATION	CONTACT TELEPHONE NUMBER

NAME OF PROGRAM ADVISOR	PROGRAM ADVISOR'S ADDRESS	ADVISOR'S TELEPHONE NUMBER

CLAIM INFORMATION

CLAIM IS RELATED TO: ☐ SICKNESS ☐ INJURY ☐ PREGNANCY

DATE FIRST TREATED _____

IS THIS MEDICAL TREATMENT COVERED BY OTHER INSURANCE? ☐ YES ☐ NO

IF YES, AMOUNT PAID $_____

NAME AND ADDRESS OF OTHER INSURER

IF **SICKNESS**, DATE SYMPTOMS FIRST NOTICED _____

DIAGNOSIS _____

HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF YES, WHEN DID THE CONDITION FIRST OCCUR _____

CIRCUMSTANCES _____

IF **INJURY**, STATE NATURE OF INJURY _____

STATE CAUSE, CIRCUMSTANCES AND LOCATION OF ACCIDENT

NAME AND ADDRESS OF FIRST DOCTOR CONSULTED

DATE OF FIRST CONSULTATION _____

NAME AND ADDRESS OF ANY OTHER DOCTOR IN ATTENDANCE

NAME AND ADDRESS OF HOSPITAL

MEDICAL DATA AUTHORIZATION (To avoid delay, sign and give to your health care provider)

You are hereby authorized to furnish, at the request of U.S. Department of State or its accredited representative, all information which you may possess, including findings and treatment rendered, x-rays and copies of all hospital or medical records, occasioned by professional services, and hospital care rendered on my behalf.

The foregoing authorization is granted with the understanding that any legal rights I may ordinarily have to claim communications between us as privileged are hereby expressly and voluntarily waived. A photostat of this authorization shall be considered as effective and valid as the original.

DATE | INSURED'S SIGNATURE

ASSIGNMENT OF INSURANCE BENEFITS - AUTHORIZATION TO PAY

(To be completed by insured if payment is to be made directly to provider or hospital)

I hereby authorize payment directly to _____ of benefits otherwise payable to me.
I understand I am financially responsible for charges not covered by this authorization or by the U.S. Department of State insurance coverage.

DATE | INSURED'S SIGNATURE

PHYSICIAN OR SUPPLIER INFORMATION

1. PATIENT'S NAME (First Name, Middle Initial, Last Name)	2. PATIENT'S DATE OF BIRTH	3. PATIENT'S SEX	4. IS CONDITION DUE TO SICKNESS OR INJURY ARISING OUT OF PATIENT'S GRANT ACTIVITY?
		☐ MALE ☐ FEMALE	☐ YES ☐ NO

5. DATE SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED	6. DATE PATIENT FIRST CONSULTED YOU FOR THIS CONDITION	7. TO YOUR KNOWLEDGE, DOES PATIENT HAVE OTHER HEALTH INSURANCE
		☐ YES ☐ NO

8. HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? ☐ YES ☐ NO

IF **YES**, WHEN DID THE CONDITION FIRST OCCUR _____

DESCRIBE CIRCUMSTANCES _____

9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ☐ YES ☐ NO

IF **YES**, STATE PROGNOSIS _____

10. LIST MEDICATIONS USED

11. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DIAGNOSIS CODE.

t

1.
2.
3.
4.

12. A DATE OF SERVICE	B* PLACE OF SERVICE	C FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE CPT OR BSA	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES		F DAYS OR UNITS	G TYPE OF SERVICE

TOTAL CHARGES		
AMOUNT PAID		
BALANCE DUE		

I CERTIFY THAT THESE SERVICES WERE PERFORMED BY ME OR IN MY PRESENCE AND UNDER MY SUPERVISION

PROVIDER NAME			
ADDRESS			
CITY	STATE	ZIP	
PROVIDER SIGNATURE		DATE	TAX IDENTIFICATION NUMBER

*PLACE OF SERVICE CODES

1 - INPATIENT HOSPITAL
2 - OUTPATIENT HOSPITAL
3 - PHYSICIAN OFFICE
20 - PHARMACY
21 - INPATIENT HOSPICE
22 - OUTPATIENT HOSPICE
23 - PHYSICIAN OFFICE HOSPICE
24 - HOME HOSPICE
40 - PATIENT HOME
99 - OTHER LOCATIONS